



LAMOILLE NORTH SUPERVISORY UNION

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NEW ENROLLMENT CHANGE OF STATUS

EMPLOYEE - MUST COMPLETE ALL INFORMATION IN SECTIONS 1 THROUGH 7

SECTION 1 - EMPLOYEE PARTICIPANT INFORMATION

Form section for employee information including Social Security Number, Last Name, First Name, MI, Date of Birth, Home Mailing Address, City, State, Zip Code, Gender, Home Phone, Work Phone, and Current Marital Status.

SECTION 2 - DEPENDENT INFORMATION

Table with columns for dependent information: Check One, LAST NAME, FIRST NAME, MI, SEX, DATE OF BIRTH, SOCIAL SECURITY #, and Enter "Dep" Relationship Code. Includes rows for Spouse or Partner and Dep-1 through Dep-5.

DEP Relationship Codes:

C-Child (Birth/Adoption) L-Legal Guardianship\* CO-Court Order Coverage\* SP-Spouse
F-Full Time Student 19+ D-Disabled Child (attach Physician Statement DP-Domestic Partner (if covered by plan) \*\* S-Stepchild\*\*\*

\*= Attach Court Order \*\*= Attach Statement of Domestic Partnership
\*\*\* = Who is legally responsible for stepchild(s) medical bills?

Full Time Student 19+ (Please Provide):

Dependent Name
Name of School:
Expected Graduation Date:
Dependent Name
Name of School:
Expected Graduation Date:

SECTION 3 - ENROLLMENT CHOICES

Elect Dental Coverage: Single 2 Person Family
Waive Coverage: Dental (Check Box if declining coverage and complete a "Waiver of Coverage" form)

SECTION 4 - SPOUSE EMPLOYER INFORMATION

Is Spouse Employed? Yes No If yes, provide Name & Address of Employer:
Does Spouse's Employer offer medical and/or dental coverage? Medical: Yes No Dental: Yes No

SECTION 5 - OTHER COVERAGE

Form section for other coverage with columns for Policyholder Name, Policy Number, Group Number, Insurance Company Name & Address, and Effective Date. Includes checkboxes for Single, 2P, and Family.

Are you, your spouse or any dependents listed in Section 2 enrolled in Medicare? Yes No
If yes, attach a copy of Medicare card(s). Actively Working Retired Under Age 65 ESRD (End Stage Renal Disease)

SECTION 6: HIPAA COMPLIANCE

Will this plan replace existing health insurance coverage? YES NO If yes, attach a certificate of prior health insurance coverage. Your Prior insurer will give you this form.

SECTION 7: SUBSCRIBER SIGNATURE

I certify that the statements on this enrollment form and all information furnished by me are true and complete to the best of my knowledge. I and any enrolled dependants agree to permit any healthcare provider to release/disclose any information (including Protected Health Information) acquired in connection with any past or future care or treatment to Comprehensive Benefits Administrator, Inc. \ Employee Benefit Plan Administration, Inc., or its designated agent for purposes of administering healthcare coverage.

Signature lines for Subscriber's Signature and Date.

\*\*\*\*EMPLOYER USE ONLY - EMPLOYER CHECK AND COMPLETE APPROPRIATE AREAS BELOW\*\*\*\*

Form section for employer use only including Coverage Effective Dates, Employee Status, Reason for Status Change, and Cancel Coverage.